

**Dental & Vision Care Plan Disenrollment Form****A) Primary Member Information:**

Name (Last, First, Middle Initial): _____

SSN: _____

☐ Male ☐ Female

Birth Date: _____

Business Phone: _____

Home Phone: _____

B) Disenrollment Information:**Dependents to be disenrolled from:**☐ Dental☐ Vision

					FOR BENEFITS USE ONLY	
Dependent(s) Name(s)	Relationship to Employee	Gender	Birth Date	Social Security #	Effective Date	Cancel Date

Reason for Dependent Disenrollment _____

Effective Date _____

C) Sign below to authorize the disenrollment of the above dependent(s) from your dental and/or vision insurance:_____
Employee Signature_____
Date**D) If applicable, remove the dependent(s) listed above from your other insurances and update your beneficiaries.**

Note: This form must be received by the Benefits Customer Service Center within 31 days of the mid-year election change event if your premiums are deducted on a pre-tax basis.

Fax this form to 505-844-7535 or mail to:

Sandia National Laboratories
Attn: Benefits Customer Service
PO Box 5800 MS 1022
Albuquerque, NM 87185-1022

For Benefits Use Only:

Date change entered in SNL database: _____

Benefits Employee Signature